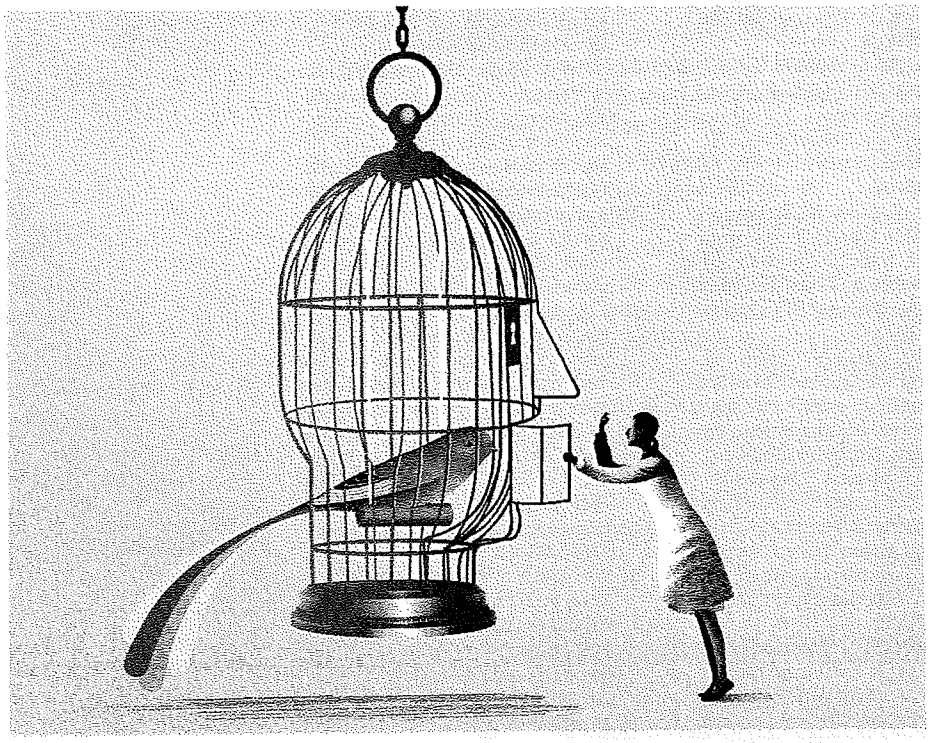

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The Promises And Pitfalls Of Treating Addiction

Treatment of addiction in primary care should increase, but it will fail without the proper supports for providers in place.

BY JESSICA L. GREGG

J was in his mid-twenties—tall and skinny, with eyes red from crying and lack of sleep. He jiggled his feet and shifted from side to side as he spoke, too high and too anxious to sit still. He told me he used heroin to forget his problems, meth when he'd used too much heroin, and pot to calm the crazy thoughts that kept him up at night. He was like a mad scientist, calibrating and recalibrating the chemicals in his brain, searching for an alchemical sweet spot.

But he was also hopeful: maybe this time, this doctor, this clinic. Maybe, he said, he could get clean and stay clean. We talked about his depression and anxiety, the troubles he had showing up for his job at a gas station, and his family problems. He said he'd been incarcerated for drug-related crimes, but that was a few years ago. He told me he leaned on friends when things got difficult, but he also told me that he had no friends who didn't use drugs.

I thought J would do well on a medication called buprenorphine. It would take care of his opioid cravings and help him stop using heroin. He would need to place the pill under his tongue for fifteen minutes. It would be bitter, but he should keep it there and let it dissolve entirely. We agreed that I would see him weekly and that he would meet with the clinic's counselor. I tugged at my short hair as I wrote his prescription, inadvertently causing segments of it to stand on end. Just before J left the room, exhausted and with his eyes red-rimmed, he tilted his head to one side.

"You look funny with your hair stuck up on one side like that," he said. "Like Dr. Alfalfa."

After a few weeks, J described treatment with buprenorphine as "a miracle." He stopped using heroin, and without heroin he didn't need meth. Without the meth, he was sleeping better and smoking less pot. He was on time for appointments, met regularly with the clinic counselor, and proved to be a funny, no-nonsense guy.

During a visit during J's second month on the medication, I told him, "You know, when my kids get older, I want to give up my car and take public transportation, like you do."

J replied, with a mixture of affection and disbelief, "You didn't go to medical school to take the fucking bus."

I laughed, and so it went: good clinical encounters, stable employment, life on track. J was a wry, delightful poster boy for recovery.

Until he wasn't.

After a few months, J started using meth again. Then pot. First occasionally, then almost daily. He couldn't pinpoint a specific event that caused the relapse and said he didn't have any desire to use heroin again. But he still needed a place for his mind to go when his dad, whom he lived with off and on, got drunk and belligerent. He needed something to do with his old friends when they came around. He needed an escape from unnamed but remembered "bad things" he'd done and couldn't take back, and he needed help with the depression that still came in waves. He said he was in trouble at work and was afraid he'd lose his job. But he kept showing up for appointments—at least most of them—and as far as I could tell he still wasn't using opioids.

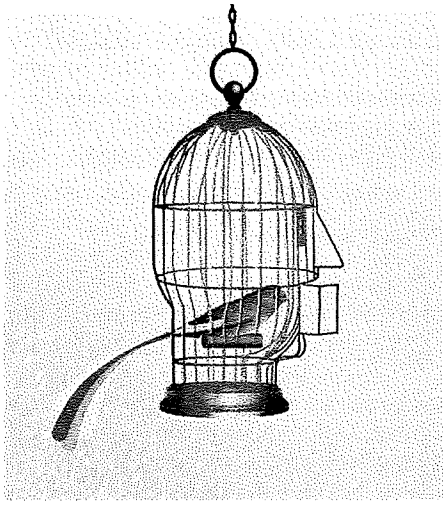
Illustration by Brett Ryder

Treating Addiction In Primary Care

I have spent over a decade treating addiction in some form or another: in primary care, detox facilities, methadone clinics, and alcohol and drug treatment centers. I have a DATA (or Drug Addiction Treatment Act of 2000) waiver, which means that I can prescribe buprenorphine, a medication that cuts mortality from opioid addiction by more than 50 percent. Like all buprenorphine prescribers, I am limited in terms of the number of patients I can treat under my DATA waiver, but I am willing to treat as many as I am legally allowed. I also regularly prescribe naloxone, a medication that could save J's life should he ever experience an opioid overdose. With those medications in hand, J's chances of surviving his addiction, even after relapse, improved markedly.

And I don't just prescribe. As part of my work, I also spend a great deal of time urging other physicians, particularly primary care physicians, to use these medications. Primary care successfully screens for, monitors, and treats other complex chronic conditions. I argue that addiction is just one more. I note the importance of the trusting relationships many patients already have with their primary care providers and point out that treatment of addiction can result in better care for other diseases. The medications save lives, I tell my colleagues; they should prescribe them.

But as I do all this, I also worry. Primary care is already overwhelmed and overburdened. Providers are being asked to do the same amount of work in less time with little support and increasingly complex patients, many of whom suffer from multiple comorbid chronic conditions. And while at times addiction management is straightforward, at many other times it is not. There are patients like J, who was benefiting from buprenorphine but also clearly struggling with other addictions and depression—all in the context of limited social support. When he relapsed, I wondered if he was diverting any of his medication to his still-using friends, or if he sold it for extra income. I thought he might need more than our clinic could provide, but I wasn't exactly sure what the next steps should be or how to take them. I didn't know if I was required to



talk to his probation officer, or if he even still had one. I didn't know what, exactly, probation officers do.

But I had the good fortune to see J in a clinic that was created specifically to treat patients suffering from addiction. I had resources and support. When he started using meth again, we had a workflow that automatically increased both his contacts with us and his urine drug screens. We also had someone dedicated to conducting pill counts and checking the prescription drug monitoring database, and we had a counselor who knew where to call to get J on a list for urgent mental health care. When he said he had no one in his life who didn't use drugs, we arranged for him to meet with the clinic's peer navigator—someone who could provide support and who understood drug courts, warrants, and probation. We had time, colleagues, and workflows in place to support J, and each other.

I wonder how patients like J would fare in a typical primary care practice. What would have happened if I hadn't had those supports? What if he had been squeezed into a fifteen-minute appointment, perhaps between one patient recently discharged from the hospital with new onset heart failure and another with schizophrenia and diabetes, and it was just me—no workflow, no counselor, no peer navigator. Overwhelmed, out of time, and unsure what to do next, I wonder how long I would have agreed to treat him.

What if J also had chronic pain? What if he was one of the thousands of patients whose pain I would only a few years ago have struggled to contain with opioids and then more opioids? After prescribing opioids for his pain and then prescribing buprenorphine for his opioid addiction, in a different clinic and without a team supporting me, would I have had the emotional and operational resources to treat his comorbid pain, opioid, and stimulant addictions? I doubt it.

Supporting Providers

On November 3, 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis released its final report. Among its recommendations, the report called for the expanded use of medication to treat addiction, federal incentives to enhance access to those medications, and a mandate requiring providers in federally qualified health centers to be licensed to prescribe buprenorphine. The report also stressed the need for more education about pain management and addiction, both for trainees and for practicing physicians. I think these are excellent recommendations.

But I also know that primary care providers need more than incentives, mandates, and education. They need resources to do this work successfully. Yes, there are heroic physicians who treat opioid addiction and its multiple comorbidities in primary care with few resources other than their own empathy, passion, and long clinical hours. They manage. But that kind of passion and dedication isn't scalable. To effectively increase access to medications that treat addiction, systems must be put into place that make it possible for everyone, including people with less passion for this work, to shoulder the task.

This does not mean that every clinic that treats addiction needs counselors or social workers or dedicated addiction treatment groups. Research shows that buprenorphine decreases morbidity and mortality from opioid addiction even if nothing else in a patient's life changes. However, what it *does* mean is that, at the very least, providers and clinic staff must not just be educated about substance disorders. They must also be given time and support to develop workflows that anticipate a patient's relapse, transforming that from a crisis into a

Policy Checklist

The issue: There is an increasing need to treat patients with addiction in the primary care setting, not just in specialized treatment facilities. However, many primary care providers lack the resources and support needed to treat addiction in their practices. This must change.

Related Reading:

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known possibility with established next steps. In addition, they must be provided with the time to create connections that make next steps possible—whether those steps include community mental health services, methadone clinics, or emergency housing. There is a debate about the usefulness of psychosocial interventions such as counseling and fellowship programs (like 12-step programs) in combination with medication for the treatment of addiction. But those interventions are clearly effective for some people. So those connections should also be in the provider's toolbox, available to support patients and providers alike as they grapple with this complicated condition.

Additionally, providers, administrators, and staff members should know whether syringe exchange programs exist in their communities. They should have the chance to observe these programs at work, and to learn how exchanges reduce the harms associated with drug use while also providing people who use drugs with opportunities to build relationships and get support. A provider may or may not choose to continue prescribing medication to a patient who continues to inject drugs. But if that provider knows about syringe exchanges—what they do, and where and when they operate—she or he has a resource, a next step, and a way forward that doesn't seem hopeless. Making these connections and then creating and establishing workflows is time-consuming and will require concerted effort. But they are necessary.

That is the minimum. In a better scenario, clinics would have funding or billing mechanisms that would allow them to hire peer mentors and clinic coordinators to perform tasks such as counting pills prescribed for patients; scheduling urine drug screens; checking prescription databases; and coordinating care between community partners, prescribers, and pharmacies.

The best-case scenario would include all of the above plus policies that eliminate the barriers to prescribing buprenorphine. We could follow the example of France, for instance, where there are no limits to the number of patients a physician can treat with buprenorphine and where there are very few other regulatory barriers. This has led to the wide availability of buprenorphine in that country and to a dramatic decrease in drug overdose and HIV infection.

This scenario would also include financial models that depend not on paying physicians by fee-for-service but on outcomes-based reimbursement, thus allowing teams to provide the right intervention to the right person at the right time. And those outcomes should not be pegged to abstinence—which is an unreasonable outcome for this chronic condition—but to improved quality of life and to measures such as maintaining employment, engaging in care, or staying out of jail or prison. This scenario would also keep the Affordable Care Act's expansion of eligibility for Medicaid intact, making it possible for patients to afford the treatment they need.

Access to medications to treat addiction must be expanded, and quickly. But in the haste to expand treatment, it is imperative that providers be given systems and resources to treat addiction effectively. Without adequate systems in place, providers will become overwhelmed and frustrated, and patients will suffer and die. With the right systems in place—even if those "systems" include only a case manager, a provider, and a sensible workflow—providers and staff members will have the chance to experience the great satisfaction of treating addiction well. Their patients, in turn, will live. Alive, those patients will have the opportunity to access systems of care that further support their health and well-being.

When I last saw J, he was doing much better. He was still using meth occasionally, usually when he was stressed and wanted to mentally check out. But he wasn't using heroin, and with the help of the peer navigator he was trying to find housing away from his old neighborhood, to escape his belligerent dad and a lot of bad memories. Because his insurance didn't allow him to receive treatment for substance use and depression at the same facility, he didn't yet have mental health care. However, he did have a network of care that included me but went far beyond me, and that gave both of us confidence that he would find his way forward. ■

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